550

Health

Budget function 550 includes spending for health care services (which represents almost 90 percent of spending in the function), health-related research and training (10 percent), and consumer and occupational safety (about 1 percent). Spending for both health care services and health research and training has grown at an average rate of more than 10 percent a year since 1999, and spending for consumer and occupational health and safety has grown by about 6 percent a year, on average.

The largest component of spending for health care services is the federal/state Medicaid program, which funds health services for some women, children, and elderly people in low-income families, as well as people with disabilities. (The biggest federal health program, Medicare, has its own budget function, 570.) Federal spending for Medicaid has grown at an average annual rate of slightly more than 10 percent since 1999. The Congressional Budget Office projects that federal Medicaid spending will total $186 billion in 2005 and will grow at an average annual rate of slightly more than 7 percent from 2005 through 2015.

Other mandatory programs in function 550 pay for health care services for certain children in low-income families and for federal civilian or military retirees. Most of the discretionary spending for health care services is disbursed by the Centers for Disease Control and Prevention, the Health Resources and Services Administration (HRSA), the Indian Health Service, and the Substance Abuse and Mental Health Services Administration.

Spending for health research and training mainly funds the National Institutes of Health (NIH) and HRSA programs that provide grants or loans to health professionals. Funding for the NIH grew by 3 percent in 2004 and by 2 percent in 2005, after doubling between 1998 and 2003.

Federal Spending, Fiscal Years 2000 to 2005 (Billions of dollars)

						Estimate	Average Annual Rate of Growth (Percent)	
	2000	2001	2002	2003	2004	2005	2000-2004	2004-2005
Budget Authority[a]								
(Discretionary)	33.8	38.9	45.8	49.4	51.7	54.3	11.2	5.1
Outlays								
Discretionary	30.0	33.2	39.4	44.2	47.9	51.3	12.4	7.1
Mandatory	124.5	139.1	157.1	175.3	192.4	204.3	11.5	6.2
Total	154.5	172.3	196.5	219.6	240.3	255.6	11.7	6.4

a. Budget authority is artificially low in 2000 because $8.8 billion in funding was shifted to become an advance appropriation for 2001.

550-01—Mandatory

Equalize Federal Matching Rates for Administrative Functions in Medicaid

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-1,000	-1,210	-1,540	-1,640	-1,750	-7,140	-17,730

The federal government pays a portion of the costs that states incur to administer their Medicaid programs. The basic federal matching rate is 50 percent for most administrative activities. However, in some cases, the federal subsidy is higher. For example, the federal government pays 75 percent of the cost of employing skilled medical professionals for Medicaid administration, 75 percent of the cost of utilization review (the process of determining the appropriateness and medical necessity of various health care services), 90 percent of the cost of developing systems to manage claims and information, and 75 percent of the cost of operating such systems.

This option would set the federal matching rate for all Medicaid administrative costs at 50 percent. That change would save $1.0 billion in 2006 and $7.1 billion over five years.

Enhanced matching rates were designed to encourage states to develop and support particular administrative activities that the federal government considers important for the Medicaid program. Once those administrative systems are operational, however, there may be less reason to continue the higher subsidy, providing a rationale for this option. Moreover, because states pay, on average, about 43 percent of the cost of health care for Medicaid beneficiaries, they have a substantial incentive to maintain efficient information systems and employ skilled professionals.

A potential drawback of this option is that a reduced federal subsidy might cause states to cut back on some beneficial activities, with adverse consequences for program management. For example, states might hire fewer nurses to conduct utilization reviews and oversee care in nursing homes, or they might make fewer improvements to their information-management systems. However, states could allocate appropriate funding for high-priority administrative activities from other federal Medicaid funds or from state sources.

RELATED OPTIONS: 550-02 and 550-03

550-02—Mandatory

Restrict the Allocation of Common Administrative Costs to Medicaid

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-280	-320	-390	-390	-390	-1,770	-3,720

The federal government's three major public assistance programs—Temporary Assistance for Needy Families (TANF), Food Stamps, and Medicaid—have certain administrative tasks in common. For instance, during the enrollment process, each program requires that potential recipients provide information about their family's income, assets, and demographic characteristics. Before the 1996 welfare reform law, which replaced Aid to Families with Dependent Children (AFDC) and some related programs with the TANF block-grant program, all three programs reimbursed states for 50 percent of most administrative costs. As a matter of convenience, states usually charged the full amount of those common administrative costs to AFDC.

The TANF block grants are calculated on the basis of past federal welfare spending, including what the states received as reimbursement for administrative costs. Thus, whereas states had previously paid the common administrative costs of their AFDC, Medicaid, and Food Stamp programs from AFDC funds, those amounts are now included in their TANF block grants. However, the Department of Health and Human Services now requires each state to charge Medicaid's share of common administrative costs to the federal Medicaid program, even if that amount is already implicitly included in the state's TANF block grant. In effect, many states are being paid twice for at least a portion of Medicaid's share of common administrative costs.

For any state that receives such a double payment, this option would limit the federal reimbursement for administrative costs for Medicaid to the amount not included in the state's TANF block grant. Federal outlays would decline by $280 million in 2006 and by almost $1.8 billion through 2010. Overall, the reduction in Medicaid funding would equal about one-third of the common costs of administering the Medicaid, AFDC, and Food Stamp programs that were charged to AFDC in 1996—the base period used to determine the amount of the TANF block grant. (A similar adjustment has already been made in the amount that the federal government pays the states to administer the Food Stamp program.) The President's 2005 budget included a comparable proposal to reduce the federal reimbursement for Medicaid's administrative costs by $300 million to reflect the share assumed in the TANF block grant.

A rationale for this option is that it would eliminate the current implicit double payment to states. Reducing federal reimbursement, however, could hamper states' outreach activities to enroll additional eligible children in Medicaid and the State Children's Health Insurance Program. Such action could also prompt states to restrict eligibility or services for those two programs.

RELATED OPTIONS: 550-01 and 550-03

550-03—Mandatory

Reduce Spending for Medicaid's Administrative Costs

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-600	-710	-830	-960	-1,130	-4,230	-12,860

The federal government currently reimburses states for about 50 percent of the cost of managing their Medicaid programs. Under this option, the federal government would cap the per-enrollee amount that it pays each state for Medicaid administration. The cap would grow by 5 percent annually from a base-year amount that represented the per-enrollee administrative costs for which each state claimed matching payments in 2004. (An alternative strategy for reducing Medicaid's administrative costs is described in option 550-02.) In his 2006 budget, the President proposed placing caps on federal funding for each state's administrative costs rather than placing caps on per-enrollee spending.

A rationale for this option is that such a change would result in savings totaling $600 million in 2006 and $4.2 billion through 2010. (Limiting federal payments for administrative costs to a 5 percent growth rate would produce substantial savings because the actual growth rate of those costs is projected to be about 7 percent in 2005 and ensuing years.) Another rationale for implementing the option is that it would give states a stronger incentive to improve the efficiency with which they manage their Medicaid programs.

An argument against this option is that, faced with fewer administrative resources, states might cut back on some activities that could improve the functioning of their Medicaid programs. For example, they might reduce funding for efforts to combat waste, fraud, and abuse.

RELATED OPTIONS: 550-01 and 550-02

550-04—Mandatory

Increase the Flat Rebate Paid by Drug Manufacturers for Medicaid Prescription Drugs

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-1,200	-1,020	-1,160	-1,300	-1,450	-6,130	-16,050

Spending by the Medicaid program for prescription drugs increased at an average inflation-adjusted rate of 16 percent annually between 1997 and 2002, reaching $28.4 billion in 2002. With the introduction in 2006 of the Medicare drug benefit—which will transfer coverage of prescription drugs for beneficiaries with dual eligibility from the Medicaid program to Medicare—Medicaid spending for prescription drugs is expected to fall substantially. The lower level of spending, however, will still be subject to upward pressures similar to those affecting overall prescription drug spending, which is projected to continue to grow, albeit more slowly than in recent years.

The amount that Medicaid pays for a particular drug depends on two published prices: the average wholesale price (AWP), a list price published by the manufacturer; and the average manufacturer's price (AMP), which is the average price that the manufacturer actually receives for drugs distributed to retail pharmacies and mail-order establishments. For brand-name drugs, state Medicaid agencies typically pay the AWP minus a percentage (ranging from 5 percent to 15 percent, depending on the state) plus a dispensing fee. A portion of that spending is recouped by both the federal government and the state government through a rebate paid by the manufacturer to Medicaid.

For brand-name drugs, the rebate is equal to the maximum of a fixed, or flat, percentage of the AMP—15.1 percent currently—and the difference between the AMP and the "best price" at which the manufacturer sells the drug to any purchaser. An additional rebate applies if the AMP grows faster than inflation. (Makers of generic drugs must rebate 11 percent of the AMP to the state Medicaid agency.) Overall, Medicaid receives an average rebate from manufacturers of slightly more than 20 percent under the current pricing scheme (not including the additional rebate tied to price inflation).

This option would boost the flat rebate from 15.1 percent to 20 percent. The Congressional Budget Office estimates that this change would increase the average Medicaid rebate (relative to the AMP) to 23 percent, reducing mandatory federal spending by $1.2 billion in 2006 and by $6.1 billion through 2010.

Beyond reducing Medicaid spending for prescription drugs, this option could result in some private purchasers paying less for certain drugs. While many manufacturers offer large discounts to private purchasers, the best-price provision can make it relatively difficult for them to offer discounts beyond the flat rebate because any such discount is automatically made available to Medicaid as well. By increasing the flat rebate, however, more room would be created for manufacturers to offer discounts that do not trigger the best-price provision. Thus, some purchasers who now receive a discount at or near the current flat rebate for a particular drug might see a benefit.

A potential drawback of this option is that pharmaceutical firms, faced with reduced revenues, might invest less money in research and development of new drugs. In particular, a policy that reduced Medicaid payments for prescription drugs might discourage the development of new drugs in certain drug classes whose use is heavily concentrated in the Medicaid population.

RELATED CBO PUBLICATIONS: *Medicaid's Reimbursements to Pharmacies for Prescription Drugs,* December 2004; and *How the Medicaid Rebate on Prescription Drugs Affects Pricing in the Pharmaceutical Industry,* January 1996

550-05—Mandatory

Expand Medicaid Eligibility to Low-Income Parents

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	+2,270	+3,130	+4,240	+4,600	+4,940	+19,180	+50,380

In low-income families, children are much more likely than adults to qualify for public health insurance. As a result of the Medicaid expansions of the mid-1980s and the enactment of the State Children's Health Insurance Program (SCHIP) in 1997, the great majority of children in families with income below 200 percent of the federal poverty level are now eligible for either Medicaid or SCHIP. For parents, however, states generally limit Medicaid eligibility to those with income substantially below the federal poverty level ($15,670 for a family of three in 2004). Several states have expanded eligibility for public coverage to parents at higher income levels.

Under this option, states would be required to expand Medicaid eligibility to parents with income below the federal poverty level. That new requirement, which would provide coverage to 1.5 million low-income adults and children in 2006, would increase federal outlays by about $2.3 billion in that year and by about $19 billion over five years.

The main rationale for this option is to expand health insurance coverage. In 2002, more than one-third of low-income parents were uninsured. Among parents who would be newly eligible under this option, participation rates would probably be similar to rates among their children who are currently eligible for Medicaid or SCHIP. Among children currently eligible for Medicaid but not enrolled, participation might increase as newly eligible parents signed up for the same insurance coverage.

A potential drawback of this option is that expanded eligibility could result in some parents with private insurance dropping that coverage to obtain public insurance. Moreover, employers of lower-income individuals might be less inclined to offer health insurance because the perceived demand would be lessened by the availability of the new alternative coverage. Also, the increased amounts that states would be required to spend under this option could lead some states to cut back on optional health care services that they would otherwise have provided.

550-06—Mandatory

Increase Allowable Copayments for Some Medicaid Services

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-90	-270	-410	-530	-670	-1,970	-7,730

Although states are allowed a great deal of discretion in designing their Medicaid programs, federal rules have traditionally limited cost-sharing requirements for beneficiaries. For instance, copayments for most adults cannot exceed $3 for goods and services such as prescription drugs, visits to physicians, and outpatient hospital visits. For children under 18, pregnant women, and the institutionalized, copayments are not permitted. Copayments are also not allowed for some services such as family planning or emergency care. Even for populations and services for which copayments are permitted under federal law, not all states impose them, and providers are required by law to serve patients who are unable to make the copayment.

This option would raise the federal limits on allowable copayments in Medicaid—from $3 for adults and zero for children to $5 and $3, respectively. The higher copayments would apply to outpatient hospital visits, prescription drugs, nonemergency visits to emergency rooms, and visits to physicians and dentists. They would not apply to services for which copayments are currently disallowed. The Congressional Budget Office estimates that implementing this option would reduce federal outlays by $90 million in 2006 and $2 billion over five years.

An argument in favor of this option is that increased copayments would encourage a more cost-conscious use of services by beneficiaries, reducing the number of unnecessary medical services provided. Furthermore, the current copayment limits have not changed since the 1980s and thus have declined, in real (inflation-adjusted) terms, since then.

A potential drawback is that a reduction in the use of appropriate health care services could also result. For instance, previous research has shown that poorer individuals facing higher copayments displayed worse health on some measures. In another example, the introduction of copayments for prescription drugs in several state Medicaid programs was found to lead to many beneficiaries' going without their medications. A further argument against the option is that such small copayments often go uncollected by providers for various reasons, which effectively lowers their reimbursement rates.

RELATED OPTION: 050-28

550-07—Mandatory

Convert Medicaid Payments for Acute Care Services into a Block Grant

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-3,670	-5,720	-11,190	-16,960	-23,160	-60,700	-292,130

The Medicaid program funds coverage for two broadly different types of health care: acute care (including services such as inpatient hospital stays and visits to physicians' offices, and products such as prescription drugs) and long-term care (services such as nursing home care and home- and community-based assistance). The program is financed jointly by the states and the federal government, with the federal government's share determined as a percentage of overall Medicaid spending. That percentage, referred to as the federal matching rate, can range from a floor of 50 percent to a ceiling of 83 percent, depending on a state's per capita income. (The matching rate averages 57 percent nationwide.) Although the federal match helps states provide health coverage to disadvantaged populations, it may also encourage higher spending by subsidizing each additional dollar spent on Medicaid. The federal share of Medicaid outlays in 2005 is estimated to be $110.6 billion for acute care and $51.3 billion for long-term care.

This option would convert the federal share of Medicaid payments for acute care services into a block grant, as 1996 legislation did with funding for welfare programs. (Long-term care would continue to be financed using the matching rate.) Each state's block grant would equal its 2004 federal Medicaid payment for acute care, indexed to the increase in input prices faced by providers of medical care. (An "input" is a factor used in the production of medical care, such as professional labor, office space, and so on.) That change in financing would reduce federal outlays by $3.7 billion in 2006 and by $61 billion over five years. The change generates savings because federal Medicaid payments are projected under current law to grow faster than the price index. (Alternatively, block grants could be indexed both to input price increases and to the change in each state's population. In that case, savings would be $2.3 billion in 2006 and would grow at a slower rate thereafter, totaling $44 billion over five years.) In exchange for slower growth in payments, states would be given more flexibility in how they could use the funds to meet the needs of their low-income and uninsured populations.

The President's 2004 budget proposed a budget-neutral Medicaid block grant, which differed in some respects from this option. Under that plan, states could choose either to operate under current Medicaid rules or to receive separate block grants for acute care and long-term care. Those grants would include funds for both Medicaid and the State Children's Health Insurance Program and would allow significantly more flexibility in the way the programs were administered. The President's 2006 budget is less specific than the 2004 budget on the subject of Medicaid financing and proposals for block grants, but it embraces the same principles for reforming Medicaid: additional flexibility for states and no additional costs for the federal government.

A rationale for this option is that funding acute care with a block grant rather than with federal matching payments would strengthen states' incentive to spend money cost-effectively by eliminating the subsidy for each additional dollar spent on health care. As proposed in the President's 2004 budget, block grants also would be coupled with increased discretion for states to design and administer their programs. For example, states could modify the generosity of their benefit package and make corresponding adjustments in the number of people covered. In addition, block grants would eliminate states' latitude to use funding strategies designed to maximize federal assistance.

An argument against this option is that converting acute care payments to a block grant would reduce the total amount of federal support for Medicaid, which could increase fiscal pressure on the states. Also, ending federal matching payments could provide an incentive for states to scale back Medicaid spending. Unless states were willing to pay more themselves or were able to find ways to provide more cost-effective care, access to health services for lower-income people might be reduced. Another argument against the option is that distinguishing between acute and long-term care for the purposes of financing could be difficult administratively. For example, in order to facilitate their recovery, former hospital patients often require services after an inpatient stay that resemble long-term care. Finally, greater state discretion creates the potential for increased disparity across states in eligibility requirements and benefit packages.

RELATED OPTION: 550-08

550-08—Mandatory

Convert Medicaid Disproportionate Share Hospital Payments into a Block Grant

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Spending							
Budget authority	+120	+20	-40	-60	-200	-160	-3,390
Outlays	+100	0	-50	-60	-170	-180	-2,700

Hospitals that serve a disproportionately large share of low-income patients may receive higher payments from Medicaid than other hospitals do. States have some discretion in determining not only which hospitals receive those so-called disproportionate share hospital (DSH) payments but also the size of those payments—if the hospitals meet certain federal criteria. During the late 1980s and early 1990s, many states engaged in funding transfers using the DSH program to obtain increased federal Medicaid funding without raising their net spending on DSH hospitals—effectively boosting the federal matching rate above that specified in law.

To combat that practice, lawmakers enacted a series of restrictions on Medicaid DSH payments during the 1990s that included setting fixed ceilings on DSH payments to each state. The Medicare Modernization Act of 2003 raised those ceilings by $1.2 billion in 2004 and by smaller amounts in later years. The Congressional Budget Office projects that under current law, federal outlays for Medicaid DSH payments, which totaled $8.7 billion in 2004, will rise to $9.8 billion in 2010.

This option would convert the current Medicaid DSH program into a block grant to the states. The grant could be reduced below current-law levels or its future growth limited to a slower rate than that at which Medicaid DSH payments would increase under current law, or both. In exchange for less funding, states could be given greater flexibility to use the funds to meet the needs of their low-income and uninsured populations in more cost-effective ways.

As an illustration of how this option could be structured, the block grant for each state in 2006 could equal 90 percent of the state's Medicaid DSH allotment for 2005. In subsequent years, the block grant could be indexed to the increase in the consumer price index for all urban consumers minus 1 percentage point. In that case, outlay savings from this option would total $180 million through 2010. The option would increase costs at first because states do not currently spend all of their allotted money as a result of the criteria and conditions that must be met—conditions that would be removed under this option.

In addition to budgetary savings, a rationale for a block grant is that the increased latitude provided to the states could result in DSH funds' being more appropriately and equitably targeted to facilities and providers that serve low-income populations. For example, states would have greater flexibility to use those funds to support outpatient clinics and other nonhospital providers that treat Medicaid beneficiaries and low-income patients.

State governments, however, might not increase their contributions to make up for the reduction in federal subsidies. As a result, hospitals (and health care providers in general) could receive less in combined federal and state Medicaid subsidies and might not be able to serve as many low-income patients. Another potential drawback is that giving states more flexibility to allocate DSH payments could alter the distribution and amount of assistance among hospitals, possibly resulting in some hospitals' receiving less public funding than they do now. Moreover, states may already have enough flexibility under current rules to allocate DSH payments to achieve the maximum benefit.

RELATED OPTION: 550-07

550-09-Mandatory

Require States to Comply with New Rules About Medicaid's Upper Payment Limit by 2006

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-840	-600	-340	0	0	-1,780	-1,780

Until 2001, Medicaid could not pay more for hospital and nursing home services than the Medicare program did. That ceiling, known as the upper payment limit (UPL), applied to total payments for services provided both by private facilities and those operated by local governments. Because Medicaid's payment rates are typically lower than Medicare's, many states were able to generate additional federal matching funds by inflating their payment rates for services provided at local government facilities. The states then would recover the inflated portion of those payments from the facilities. That process effectively increased federal payments to states without raising the states' Medicaid expenditures, permitting the additional federal funds to be used for any purpose.

To limit states' ability to generate enhanced payments, the Department of Health and Human Services issued regulations in 2001 that created separate UPLs for private facilities and those operated by local governments. However, those regulations—required by the Benefits Improvement and Protection Act of 2000—were designed to take full effect at different times for different states. States that used the enhanced-funding mechanism the longest were allowed a transition period that stretches to September 30, 2008; the transition period of other states lasts only until the end of state fiscal year 2005. (States that sought to enhance their funding on or after October 1, 1999, are already subject to the new rules.)

This option would require that all states fully comply with the UPL regulations beginning in 2006. That requirement would reduce federal outlays by $840 million in 2006 and $1.8 billion through 2010.

A rationale for this option is that eliminating the extended transition period would treat all states the same, which is more equitable than allowing some states to continue, in effect, to obtain a higher federal matching rate than that specified in law. An argument against this option is that the extended transition period permits states with the longest history of relying on enhanced payments more time to adjust their budgets to the smaller federal payments resulting from the new regulations.

550-10—Mandatory

End the Redistribution of Unused Federal Funds from the State Children's Health Insurance Program

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-20	-20	-70	-100	-140	-350	-1,140

The State Children's Health Insurance Program (SCHIP) provides health care coverage to certain uninsured low-income children whose annual family income is too high for them to qualify for Medicaid. Depending on the per capita income in a given state, the federal government reimburses between 65 percent and 85 percent of the state's total SCHIP spending (compared with reimbursement of between 50 percent and 83 percent of total Medicaid spending). A state may provide coverage through SCHIP by expanding its Medicaid program, setting up a separate program, or combining the two approaches. When SCHIP was established in 1997, the Congress appropriated approximately $4.3 billion annually for 1998 through 2001, $3.2 billion annually for 2002 through 2004, $4.1 billion annually for 2005 through 2006, and $5.0 billion for 2007. Consistent with statutory guidelines, the Congressional Budget Office's (CBO's) baseline assumes that $5.0 billion will continue to be appropriated in each year after 2007.

Each state receives an annual allotment from the total appropriations on the basis of factors such as the number of low-income children living in the state and the average annual wages of health care workers in the state. States have three years to spend their allotments. At the end of the third year, the Secretary of Health and Human Services reallocates any unused funds to states that have spent their entire allotments. Those redistributed funds generally are available for one additional year. The first such redistribution of unused funds took place in 2001, when about $700 million that originally was allocated in 1998 was redistributed to 12 states. The redistribution of 1999 allotments totaled $1.6 billion.

This option would leave the basic SCHIP program intact but would end future redistributions of unspent funds. If implemented, such action would save $20 million in federal outlays in 2006 and $350 million over five years. CBO's estimate assumes that states will partly offset shortfalls in SCHIP funding with higher spending in Medicaid. Compared with the amount of funds redistributed in prior years, redistributions over the next several years are expected to be relatively small because more states are likely to use all of their available funds. The states' relatively slow rate of spending in the first few years of the program may have resulted from delays in setting up such a large new program.

A rationale for this option is that recovering unspent funds from SCHIP would produce budgetary savings for the federal government with little disruption to most states' plans for providing health insurance to children from low-income families. Because states cannot know the amount of federal funds that would be redistributed to them in advance, they probably do not depend on such funding for planning and implementing their children's health insurance programs each year.

An argument against this option is that ending the redistribution of unspent SCHIP funds could reduce the financing flexibility of states that might count on those additional funds to provide health insurance to low-income children. As a result, those states might not be as ambitious about creating and maintaining their programs as they otherwise would be, or they might spend more Medicaid funds to cover children. Also, ending the redistribution could take away a useful spending cushion for states that use all of their allotments under the program.

RELATED OPTION: 550-11

550-11—Mandatory

Adjust Funding for the State Children's Health Insurance Program for Increases in Health Care Spending and Population Growth

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	0	0	+30	+130	+220	+380	+3,780

Enacted as part of the Balanced Budget Act of 1997, the State Children's Health Insurance Program (SCHIP) provides health care coverage for certain uninsured children from low-income families. States administer the program through their Medicaid programs, a separate program, or a combination of both. The program, which began operation in 1998, is authorized through 2007. Consistent with statutory guidelines, the Congressional Budget Office's (CBO's) estimates assume that funding for the program in later years will continue at the 2007 level. That assumed funding for SCHIP does not take into account the rising cost of medical care or the increasing size of the population of children.

This spending option would index SCHIP funding after 2007 to the growth rates in health spending and in the number of children. CBO assumes, on the basis of the most recent projections of national health expenditures from the Centers for Medicare and Medicaid Services (CMS), that per capita health expenditures will grow by 6.3 percent annually after 2007. In CBO's estimation, this proposal would increase SCHIP spending by $30 million in 2008 and by a total of $380 million through 2010.

An argument for this option is that without such a funding increase, many states will be unable to maintain their level of benefits and coverage beyond 2007. To stay within budget, states either will have to reduce the level of benefits they provide to recipients, restrict the number of low-income children deemed eligible for aid, or some combination of the two. Those outcomes would not be consistent with the statutory objectives of the program.

An argument against this option is that, so far, there has been little need to increase funding to maintain coverage rates. States have been slow to spend their current allotments of SCHIP funds, and CBO estimates that states will still have about $5.0 billion in unspent funds at the end of 2007. Moreover, some states have used unspent SCHIP funds to expand coverage to low-income adults under section 1115 of the Social Security Act, which allows the Secretary of Health and Human Services to waive many of the statutory requirements of Medicaid and SCHIP in cases of experimental, pilot, or demonstration projects that promote program objectives. As of January 2004, the Department of Health and Human Services has approved 14 SCHIP waivers from states. To adjust SCHIP funding for inflation in medical costs, therefore, states could draw upon funds used to cover adults without increasing overall program funding.

RELATED OPTION: 550-10

550-12—Mandatory

Create a Voucher Program to Expand Health Insurance Coverage

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	+2,660	+4,240	+5,240	+5,560	+5,630	+23,330	+53,000

Approximately 20 million people in the United States lacked health insurance throughout 2002, and over 40 million were uninsured on a typical day that year. Fewer than a fourth of those who were uninsured for the entire year had access to health care coverage through an employer, even though more than half were in families with at least one working adult. To extend coverage to the uninsured, policymakers have proposed various options, including the following: offering direct subsidies or tax inducements to individuals who purchase coverage or to firms who offer it to their employees; expanding Medicaid and the State Children's Health Insurance Program (SCHIP); reforming rules that regulate private insurance; and requiring employers to offer coverage.

One proposal would create a voucher that uninsured people could use to help purchase coverage in the individual health insurance market. The option considered here would pay up to $1,000 per year for an individual and up to $2,750 for a family to defray the cost of insurance premiums in the individual health insurance market. The voucher would pay no more than 70 percent of the premium, would be fully available only to people with income below 200 percent of the federal poverty level (the value of the voucher would be phased out for people with income between 200 percent and 250 percent of the poverty level), and would not be subject to taxation as income. It also would not be available to individuals who were offered insurance through their employer when the employer paid at least 50 percent of the premium. Individuals could not simultaneously receive the subsidy and be enrolled in Medicare, Medicaid, or SCHIP.

Implementing that voucher program would cost nearly $2.7 billion in 2006 and $23 billion over five years, the Congressional Budget Office (CBO) estimates. Following an initial start-up period, roughly 1.3 million otherwise uninsured individuals would be likely to enroll in the program in each year. About 75 percent of the total amount of the subsidy would go to people who otherwise (without the subsidy) would have already had insurance coverage via the individual market. Also, CBO estimates, fewer than 100,000 individuals who would have been insured through Medicaid would purchase private coverage, and several hundred thousand would switch from their employer-provided coverage to less expensive coverage (given the new subsidy) in the individual market.

Finally, approximately 200,000 people would be likely to lose insurance coverage under this option as some small employers elected not to offer insurance because of the new subsidies. As health insurance in the individual market became less expensive with the government subsidy, some firms, in CBO's estimation, would opt to provide their employees with higher cash wages rather than offer health insurance. Although such a change might benefit a firm's employees on average, some previously insured employees could face higher premiums in the individual market (perhaps because of adverse health conditions) and might forgo insurance coverage altogether. Those higher cash wages would result in increased revenues from income and payroll taxes over the 2006-2015 period of more than $1 billion (not included in the table).

A rationale for implementing this option is that extending health insurance coverage to more people could have beneficial consequences. A lack of health insurance is linked to reduced access to regular, timely health care services, poorer health outcomes, and increased strain on providers such as public hospitals and emergency rooms. Moreover, subsidies for the purchase of insurance in the individual market would work toward balancing the favorable tax treatment currently accorded only to employer-provided health insurance: under current law, employers' contributions to their employees' health insurance premiums are deductible as a business expense but are not taxable as income to employees.

A potential drawback of this voucher option is that most of the funds would go to eligible people who otherwise would have had insurance coverage even without the subsidy, and therefore the option would not advance the main purpose of the program. In addition, although the option would expand health insurance coverage overall, it could reduce coverage rates for a small number of workers whose employers dropped their coverage because of the new subsidy. Further, the option probably would not increase coverage a great deal for people who cannot access work-based insurance and are charged very high premiums in the individual market because of preexisting or chronic medical conditions.

RELATED CBO PUBLICATION: *How Many People Lack Health Insurance and For How Long?* May 2003

550-13—Discretionary and Mandatory

Adopt a Voucher Plan for the Federal Employees Health Benefits Program

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Discretionary Spending[a]							
Budget authority	-400	-900	-1,400	-1,900	-2,500	-7,100	-29,500
Outlays	-400	-900	-1,400	-1,900	-2,500	-7,100	-29,500
Change in Mandatory Spending							
Budget authority	-300	-800	-1,300	-1,800	-2,300	-6,500	-27,900
Outlays	-300	-800	-1,300	-1,800	-2,300	-6,500	-27,900

Note: Estimates do not include savings realized by the Postal Service.

a. Savings measured from the 2005 funding level adjusted for premium increases and changes in employment.

The Federal Employees Health Benefits (FEHB) program provides health insurance coverage to 4.1 million federal workers and annuitants, as well as to their 4.3 million dependents and survivors, at an expected cost to the government of almost $25 billion in 2006. Policyholders are required to pay at least 25 percent of the premium of whatever plan they choose. (Premium payments are deducted from pretax income, as they are for workers in the private sector.) That cost-sharing structure encourages federal employees to switch from higher-cost to lower-cost plans to blunt the effects of rising premiums; it also intensifies competitive pressures on all participating plans to hold down premiums. Overall, the federal government's share of premiums for employees and annuitants (including for family coverage) is 72 percent of the weighted average premium of all plans. (The share is higher for Postal Service employees under that agency's collective bargaining agreement.)

This option would offer a flat voucher for the FEHB program that would cover the first $3,370 of premiums for individual employees or retirees or the first $7,680 for family coverage. Those amounts, which are based on the government's average expected contribution in 2005, would increase annually at the rate of inflation rather than at the average weighted rate of change for premiums in the FEHB program. Indexing vouchers to inflation rather than to the growth of premiums would produce budgetary savings because the Congressional Budget Office expects FEHB premiums to grow three times as fast as inflation under current law. That change could reduce discretionary spending (because of lower payments for current employees and their dependents) by $400 million in 2006 and a total of $7.1 billion over five years. It would also reduce mandatory spending (because of lower payments for retirees) by $300 million in 2006 and $6.5 billion over five years.

An advantage of this option is that removing the current cost-sharing requirement would strengthen price competition among health plans in the FEHB program. For plans costing more than the amount of the voucher, enrollees would be faced with paying the full amount of premiums above the level of the voucher rather than a percentage, as currently required. Moreover, insurers would have greater incentive to offer more-efficient and lower-cost plans to attract participants, because enrollees would pay nothing for plans costing the same as or less than the amount of the voucher.

This option would have several drawbacks, however. First, if premiums continued to rise as expected, participants would pay an ever-increasing amount—possibly equaling more than an additional $1,680 per worker (or about 45 percent of their premiums) in 2010 and more in later years. Second, large private-sector companies currently provide better health benefits for employees (although not for retirees) than the government does, which makes it harder for the government to attract highly qual-

ified workers. That discrepancy would increase under this option. Third, in the case of current federal retirees and long-time workers, this option would cut benefits that have already been earned. Finally, it could strengthen existing incentives for plans to structure benefits so as to disproportionately attract people with lower-than-average health care costs. That "adverse selection" could destabilize other health care plans.

RELATED OPTION: 550-14

RELATED CBO PUBLICATIONS: *The President's Proposal to Accrue Retirement Costs for Federal Employees,* June 2002; and *Comparing Federal Employee Benefits with Those in the Private Sector,* August 1998

550-14—Mandatory

Base Federal Retirees' Health Benefits on Length of Service

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays[a]	-130	-210	-300	-400	-520	-1,560	-6,330

a. Estimates do not include savings realized for Postal Service retirees.

Federal retirees are generally allowed to continue receiving benefits from the Federal Employees Health Benefits (FEHB) program if they have participated in the program during their last five years of service and are eligible to receive an immediate annuity. More than 80 percent of new retirees elect to continue health benefits. For those over age 65, FEHB benefits are coordinated with Medicare benefits; the FEHB program pays amounts not covered by Medicare (but no more than what it would have paid in the absence of Medicare).

Participants in the FEHB program and the government share the cost of premiums. The cost-sharing provision sets the government's share for all enrollees at 72 percent of the weighted average premium of all participating plans (up to a cap of 75 percent of the premium for any individual plan). In 2006, the government expects to pay $7.8 billion in premiums for 1.4 million nonpostal retirees plus their dependents and survivors.

This option would reduce health benefits for retirees who had relatively short federal careers, although it would preserve their right to participate in the FEHB program. For new retirees only, the government's share of premium costs would be cut by 2 percentage points for every year of service less than 30. In the case of a retiree with 20 years of service, for example, the government's contribution would decline from 72 percent of the weighted average premium to 52 percent. That change would reduce mandatory spending by $130 million in 2006 and by almost $1.6 billion over five years (excluding savings realized for Postal Service retirees).

About 60 percent of the roughly 60,000 new nonpostal retirees who continue in the FEHB program each year have less than 30 years of service. The average new retiree affected by this option would pay about 50 percent of his or her premium rather than 30 percent, an annual increase of approximately $1,500 in 2006. (Annuitants tend to enroll in more-expensive plans than employees do; thus, they pay a greater share of their average premiums.)

A rationale for this option is that it could make the government's mix of compensation fairer and more efficient by improving the link between length of service and deferred compensation. It would also help bring federal benefits closer to those of private companies. Federal retirees' health benefits are significantly better than those offered by most large private firms, which have been aggressively paring or eliminating retirement health benefits for newly hired workers in recent years. According to a 2001 survey by Watson Wyatt, a benefits consulting firm, most of the roughly 40 percent of medium and large U.S. employers that still provide medical benefits to retirees have tightened eligibility rules for new workers, typically requiring 10 or more years of service to qualify.

A disadvantage of this option is that it would mean a substantial cut in promised benefits, particularly for retirees with shorter federal careers, such as the roughly 25 percent of new retirees with less than 20 years of service. The option could also have unintentional and perhaps adverse effects on the composition of the federal workforce. For example, it might encourage some employees with short federal careers to delay retirement and induce others to accelerate their retirement plans to avoid the new rules. In the latter case, the government could have difficulty replacing a sizable number of workers at one time.

RELATED OPTION: 550-13

RELATED CBO PUBLICATIONS: *The President's Proposal to Accrue Retirement Costs for Federal Employees,* June 2002; and *Comparing Federal Employee Benefits with Those in the Private Sector,* August 1998

550-15—Discretionary

Reduce Subsidies for the Education of Health Professionals

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Spending							
Budget authority	-300	-305	-311	-317	-323	-1,555	-3,270
Outlays	-272	-291	-300	-305	-311	-1,480	-3,133

In 2005, lawmakers provided about $300 million to the Health Resources and Services Administration within the Department of Health and Human Services to subsidize institutions that educate physicians and other health care professionals. Those subsidies, which title VII of the Public Health Services Act authorizes, primarily take the form of grants and contracts to schools and hospitals. Several programs offer federal grants to medical schools, teaching hospitals, and other training centers to develop, expand, or improve graduate medical education in primary care specialties and related health fields and to encourage health care professionals to practice in underserved areas. A few programs provide funding directly to individuals for their education in the health care professions. This option would eliminate those subsidies, saving $272 million in outlays next year and $1.5 billion over five years.

An argument in favor of this option is that federal subsidies are unnecessary because market forces provide sufficient incentives for people to seek training and jobs in health care. Over the past several decades, the number of physicians—a key group targeted by the subsidies—has increased rapidly. In 2000, for example, the United States had 288 physicians in all fields for every 100,000 people, compared with just 142 in 1960.

The President's 2005 budget proposes to reduce the funding for two title VII Programs (Scholarships for Disadvantaged Students together with Health Professions Workforce Information and Analysis) and eliminate funding for most other title VII programs that subsidize the education of health professionals. In its assessment of the programs, the Office of Management and Budget noted that while the programs are well managed, they do not have a clear purpose in the authorizing legislation. Furthermore, a 1997 report by the General Accounting Office (now the Government Accountability Office) found that the effectiveness of the programs had not been demonstrated, partly because of a lack of appropriate data and clear program objectives.

However, market incentives by themselves may not be strong enough to achieve an optimal number of health care professionals. For instance, third-party reimbursement rates for primary care specialties may not encourage enough physicians to enter those fields or to provide such care in underserved areas.

RELATED OPTIONS: 570-03, 570-04, 570-05, 570-06, and 570-07

550-16—Mandatory

Finance the Food Safety and Inspection Service Through User Fees

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-357	-779	-847	-877	-908	-3,769	-8,811

The Food Safety and Inspection Service (FSIS), an agency within the Department of Agriculture (USDA), regulates the safety and proper labeling of most domestic and imported meat and poultry sold for human consumption in the United States. It also ensures the safety of certain egg products. The FSIS employs more than 7,000 inspection personnel, one or more of whom must be present at all times when a meat or poultry slaughtering plant is operating. In addition to sampling and testing meat and poultry products, inspectors monitor processing plants daily for adherence to federal standards (for instance, those governing sanitary conditions, ingredient levels, and packaging). Recently, the FSIS has also been charged with protecting the nation's meat and poultry supply from bioterrorism. The agency gets most of its funding through annual appropriations, which totaled $817 million in 2005. However, when plants operate during holidays or overtime shifts, the meat-packing industry pays the government for FSIS inspectors through user fees.

This option would finance all federal meat and poultry inspection activities (not just those that occur during holidays or overtime shifts) with user fees paid by meat and poultry slaughtering and processing firms. Implementing such a change would reduce federal outlays by $357 million in 2006 and by a total of $3.8 billion over five years. The President's 2006 budget recommends an increase in the collection of user fees but not to the extent considered in this option.

An argument in favor of this option is that users of government services should pay for those services. Federal inspections benefit both producers and consumers of meat and poultry products because they prevent diseased animals from being sold as food. But the meat and poultry industries benefit in other ways as well: for example, they can advertise that their products have been inspected by the USDA, which may enhance the quality of those products in the eyes of consumers.

An argument against implementing this option is that the current system of public financing benefits society at large, primarily by preventing the spread of disease from infected livestock to other sources of food and water.

550-17—Mandatory

Accelerate the Availability of Generic Drugs by Changing the 180-Day Exclusivity Provision

						Total	
(Millions of dollars)	2006	2007	2008	2009	2010	2006-2010	2006-2015
Change in Outlays	-1	-21	-35	-50	-62	-169	-400

Many top-selling brand-name drugs are protected by multiple patents, which can cover the substance, use, or formulation of the drug as approved by the Food and Drug Administration (FDA). Under provisions of the 1984 Hatch-Waxman Act, manufacturers of generic drugs can challenge patents on brand-name drugs. If a manufacturer can show that a patent is invalid or that it would not be infringed upon by its generic version, then the manufacturer can obtain FDA approval and market its generic version before the patent on the brand-name drug expires.

Manufacturers of generic drugs apply to the FDA for approval to produce a biologically equivalent version of a brand-name drug by filing an abbreviated new-drug application. Upon filing, they must inform the FDA and subsequently notify the manufacturer of the brand-name drug of any patents they intend to challenge. If the manufacturer that is challenging the patent is not sued by the brand-name manufacturer within 45 days or wins in court, it may be eligible for 180 days of market "exclusivity." During that six-month period, the FDA cannot approve the application of a subsequent manufacturer to produce a generic version of the same drug.

The first manufacturer to apply to produce a generic version has some flexibility regarding when to start selling its drug and, thus, when the 180-day exclusivity period begins. Under certain circumstances, the manufacturer can "park," or delay the start of, that period, preventing subsequent applicants from obtaining FDA approval for their generic version of the drug. A 2002 Federal Trade Commission study reported that in some cases, manufacturers of brand-name drugs and the first generic manufacturer to apply to produce a generic version agreed to postpone the marketing of a generic drug, which may have effectively "parked" the period of exclusivity. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 helped to reduce the extent of that practice by creating conditions under which the first applicant for a generic equivalent must forfeit its 180-day exclusivity period.

Under one of the forfeiture conditions, if the first applicant does not market its generic version within 75 days of a final court decision that all challenged patents are invalid or not infringed upon, then the applicant must relinquish its exclusivity period. The forfeiture condition applies even if a subsequent applicant is the first to obtain a final court decision of noninfringement on all challenged patents. In that case, a subsequent applicant may get to market faster because of that forfeiture condition, which "pushes" the first applicant to market its generic version (or to give up the exclusivity period). However, one way the exclusivity period may still be "parked" is if the manufacturer of the brand-name drug does not sue a subsequent applicant on at least one of the challenged patents. The absence of a lawsuit—which could mean that the manufacturer of the brand-name drug does not intend to defend its patent against infringement by the subsequent applicant—would not be sufficient to potentially trigger the forfeiture of the exclusivity period by the first generic applicant.

This option would change current law by adding to existing forfeiture conditions the absence of a lawsuit within 45 days by the manufacturer of the brand-name drug against an applicant that challenges a patent. That change could speed up the availability of lower-priced generic drugs in certain cases, such as when a subsequent applicant has built a stronger case against a challenged patent than the first applicant did and, as a result, is not sued by the manufacturer of the brand-name drug.

CBO estimates that this option will reduce direct federal spending for drugs primarily under Medicare, Medicaid, the Federal Employees Health Benefits program, and the Department of Defense by $1 million in 2006 and $169 million over five years. It also would lower the cost that

nongovernmental purchasers paid for drugs, which in turn would reduce premiums for employer-sponsored health insurance and prescription-drug spending by individuals. As a result of that reduction in premiums, more of employees' compensation would take the form of taxable income, thus increasing tax revenues by less than $500,000 in 2006 and by $63 million through 2010 (not included in the table).

A potential drawback of this option is that drug manufacturers' incentive to invest in the development of new drugs could weaken if sales of brand-name drugs fell. That effect would probably be small, however, because any decrease in profits would occur toward the end of a drug's market life and thus manufacturers would strongly discount it when originally deciding whether to invest in research and development.